Fact Sheet on Programmatic Example

(Note: this is just an example of the type of evidenced based or promising practice that may implement all or part of a BSK strategy.)

Strategy to be Addressed:

Build Resiliency of Youth and Reduce Risky Behaviors; Domestic Violence Prevention

Program Name:

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Fourth R - Skills for Youth Relationships

Brief Program Description:

CBITS - a school-based, group and individual intervention for students, with testing primarily in grades three through eight, but expansion now to high school students. CBITS is designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills among students exposed to traumatic life events, such as domestic violence, physical abuse, accidents, community and school violence or a catastrophic event, such as a natural disaster. CBITS uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and imaginal exposure). The program includes 10 group sessions, one to three individual sessions with students, two parent sessions and a teacher education session.

Fourth R – a school-based curriculum for youth designed to promote healthy and safe behaviors related to dating sexuality and substance abuse. The curriculum is based on social learning theory to improve students' relationships with dating partners and peers and to avoid symptomatic problem behaviors, including violence and aggression. Each unit of the program consists of seven classes of one hour and fifteen minutes each delivered by a well-trained teacher.

Prevention Results Achieved Elsewhere or in K.C. Pilot:

CBITS - Testing findings include significant reduction in PTSD symptoms; reductions in symptoms of depression and psychosocial dysfunction.

Fourth R - Testing findings include reduction in dating violence and reduction in violent delinquency, particularly in students with a history of childhood maltreatment.

Target Population and number of people served:

CBITS - Program can be used for students from grade three through high school. For each school using the program, with one devoted mental health professional or well-trained social worker to focus on the program, up to 30 CBITS groups can be run in a school district each year (up to approximately 210 students). Students are screened into the program through a screening assessment.

Fourth R – The Fourth R is designed to be used universally with all middle school and high school students, but could be scaled in any manner desired.

Estimated Cost to Administer:

CBITS - The cost, including staffing at schools, is approximately $430 per student; and the cost for 10 schools is approximately $905,500. The literature identifies the group sessions of the program as capable of being covered by Medicaid; assuming this Medicaid coverage would bring the cost down to approximately $400,000 per 10 schools.

Fourth R - The cost, including expenses for teacher training and curriculum materials, is approximately $16 per student. To run the program in all schools in King County at the Middle and High Schools would costs approximately $2 million per year; to run the program in the entry level classes of these schools would cost approximately $600,000 per year.

Estimated Cost Savings to Community:

Several studies have found that the majority of children exposed to violence display symptoms of post-traumatic stress disorder (PTSD), and a substantial minority develop clinically significant PTSD. Exposure to violence alone has several negative effects, including depression, behavioral problems and violence, poor school performance, decreased IQ and reading ability, lower grade point averages and developmental problems, even if the children did not develop PTSD. These programs have a proven track record of reducing symptoms of PTSD and depression and improving psychosocial functioning, relationships and classroom behavior. These positive impacts help to reduce much more costly behavioral problems, depression, etc., as cited above, that may occur from exposure to violence. Cost modeling on the amount of cost savings for these programs has not yet been completed.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS has been tested primarily with children in grades 3 through 8, as in the three studies reviewed in this summary. It also has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma and/or were exposed to a catastrophic weather event such as Hurricane Katrina.

CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel.

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	**Review Date: March 2010** 1: PTSD symptoms 2: Depression symptoms 3: Psychosocial dysfunction
Outcome Categories	Mental health Social functioning
Ages	6-12 (Childhood)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	School
Geographic Locations	Urban
Implementation History	Since it was first used in the 2000-2001 school year, CBITS has been implemented widely across the United States and is being actively disseminated through the National Child Traumatic Stress Network. Implementation sites have been located in California, the District of Columbia, Illinois, Louisiana, Maryland, Mississippi, Montana, Tennessee, and Wisconsin, among other States. Internationally, CBITS is being implemented in Australia, China, Guyana, and Japan.
...l Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	CBITS has been adapted for use with traumatized Latino immigrant children, and worksheets and parent handouts have been translated into Spanish. The program also has been adapted for use in American Indian reservation schools to reflect the traditional culture and wellness practices of the participating tribes. In

	addition, program worksheets have been adapted for use among low-literacy populations and youth in foster care.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research

Review Date: March 2010

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Stein, B. D., Elliott, M. N., Tu, W., Jaycox, L. H., Kataoka, S. H., Fink, A., et al. (2003). School-based intervention for children exposed to violence [Reply]. Journal of the American Medical Association, 290(19), 2542.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. Journal of the American Medical Association, 290(5), 603-611.

Study 2

Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., et al. (2003). A school-based mental health program for traumatized Latino immigrant children. Journal of the American Academy of Child and Adolescent Psychiatry, 42(3), 311-318.

Study 3

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. Journal of Traumatic Stress, 23(2), 223-231.

Supplementary Materials

Foa, E., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. Journal of Clinical Child Psychology, 30(3), 376-384.

Jaycox, L. H., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudera, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child and Adolescent Psychiatry, 41(9), 1104-1110.

Morsette, A., Schuldberg, D., van den Pol, R., Swaney, G., & Stolle, D. (2009). Culturally informed cognitive behavioral interventions for trauma symptoms: Group therapy in rural American Indian reservation schools. Manuscript submitted for publication.

Outcomes

Outcome 1: PTSD symptoms	
Description of Measures	The Child PTSD Symptom Scale (CPSS), the children's version of the Posttraumatic Diagnostic Scale for Adults, was used to assess PTSD symptoms. The CPSS is a 17-item self-report measure that asks children to rate how often in the past month they were bothered by symptoms on a scale from 0 (not at all) to 3 (almost always), yielding a total score ranging from 0 to 51, with higher scores indicating more PTSD symptoms.
Key Findings	In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean CPSS score at 3-month follow-up than the wait-list group (8.9 vs. 15.5; $p < .001$). The effect size for this finding was large (Cohen's $d = 1.08$). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CPSS scores was no longer significant (8.2 vs. 7.2). In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CPSS score decreased significantly from 19 to 13

	(p < .001), while the wait-list group had a nonsignificant decrease from 18 to 16. In addition, in a subsample analysis of students with clinically significant PTSD symptoms at baseline (CPSS score > 11), the improvement in mean CPSS score was significantly greater for the intervention group (from 20 to 13) than for the wait-list group (from 19 to 16; p < .05). In a third study, students in grades 4-8 who reported significant levels of mental health symptoms including PTSD were randomly assigned to receive CBITS or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Mean CPSS scores improved significantly from baseline to 10-month follow-up in both groups, decreasing from 22.82 to 12.00 for the TF-CBT group (p < .01) and from 21.98 to 15.81 for the CBITS group (p < .001). While both treatments led to a significant reduction of PTSD symptoms, the difference between groups was not statistically significant.
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.1 (0.0-4.0 scale)

Outcome 2: Depression symptoms

Description of Measures	Symptoms of depression were assessed using the Children's Depression Inventory (CDI). The CDI is a 27-item self-report instrument that assesses cognitive, affective, and behavioral symptoms of depression in children. Twenty-six of the 27 items were used; 1 item assessing suicidality was removed at the request of school personnel. For each item, the child was asked to describe his or her feelings during the past 2 weeks, with three possible response options associated with scores of 0 (an absence of symptoms), 1 (mild symptoms), and 2 (definite symptoms). Scores range from 0 to 52 points, with higher scores indicating more depressive symptoms.
Key Findings	In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a lower mean CDI score at 3-month follow-up than the wait-list group (9.4 vs. 12.7; p = .014). The effect size for this finding was small (Cohen's d = 0.45). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CDI scores was no longer significant (9.0 vs. 10.0). In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CDI score decreased significantly from 16 to 14 (p < .001), while the wait list group's mean CDI score remained unchanged at 16. In addition, in a subsample analysis of students with clinically significant depression symptoms at baseline (CDI score = 18), the improvement in mean CDI score at 3-month follow-up was significantly greater for the intervention group (from 23 to 18) than for the wait-list group (from 24 to 23; p < .05). In a third study, students in grades 4-8 who reported significant levels of mental health symptoms including PTSD were randomly assigned to receive CBITS or TF-CBT. Mean CDI scores improved significantly for both groups from baseline to 10-month follow-up, decreasing from 15.43 to 11.14 for the TF-CBT group (p = 0.17) and from 13.40 to 9.72 for the CBITS group (p < .001).
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 3: Psychosocial dysfunction

cription of Measures	Psychosocial dysfunction was assessed using the 35-item Pediatric Symptom Checklist (PSC). This instrument asks the child's parent to rate the frequency of the child's emotional and behavioral problems on a scale from 0 (never) to 2 (often), yielding a total score of 0 to 70 points, with higher scores indicating greater dysfunction.
Key Findings	Sixth-grade students who reported exposure to violence and had clinically significant PTSD

	symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean PSC score at 3-month follow-up compared with the wait-list group (12.5 vs. 16.5; p = .007). The effect size associated with this finding was medium (Cohen's d = 0.77). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean PSC scores was no longer significant (9.4 vs. 8.9).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood)	56% Female 44% Male	100% Race/ethnicity unspecified
Study 2	6-12 (Childhood)	50% Female 50% Male	100% Hispanic or Latino
Study 3	6-12 (Childhood)	56% Female 44% Male	48% White 46% Black or African American 5% Hispanic or Latino 1% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: PTSD symptoms	4.0	4.0	2.0	3.0	2.0	3.5	**3.1**
2: Depression symptoms	4.0	3.5	2.0	3.0	2.0	3.5	**3.0**
3: Psychosocial dysfunction	3.5	4.0	3.0	3.5	2.5	4.0	**3.4**

Study Strengths

Relevant and psychometrically sound measurement instruments were used in the studies. The measures have high levels of reliability and validity and have been widely used in other studies. Missing data were handled well and were factored into analyses (e.g., analyses used multiple imputation; intent-to-treat was used in two of the studies). A variety of analyses were used across the three studies, and the analyses generally were appropriate for the type of data collected.

Study Weaknesses

Despite the availability of a treatment manual and clinician training, the methods used to assess intervention fidelity varied across the three studies and overall were not systematically strong. Several important confounding variables were not resolved in the studies, including baseline differences between completers and noncompleters, lack of blinding to treatment condition, a mixed approach to

making condition assignments, and differential attrition across treatment groups.

Readiness for Dissemination

Review Date: March 2010

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Cognitive Behavioral Intervention for Trauma in Schools Dissemination Toolkit

Jaycox, L. (2004). Cognitive Behavioral Intervention for Trauma in Schools. Longmont, CO: Sopris West Educational Services.

Program Web site, http://www.tsaforschools.org/index.php?option=com_content&task=view&id=81&Itemid=69

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	3.5	**3.8**

Dissemination Strengths

Implementation materials are thorough and well developed. The manual and toolkit are easy to read, well organized, and clearly formatted. Detail is provided on screening students for appropriateness for inclusion in the program. Training packages are comprehensive and varied. The developers are clear about the skills and competences required by clinicians and supervisors who implement the program. Ongoing support is provided via remote telephone consultation and an online peer support network and resource library. Several options for fidelity monitoring are described, including the scoring of live or audiotaped sessions, therapist self-ratings, and supervision, and forms and rating instructions are included. Fidelity monitoring is stressed as an important component of the program.

Dissemination Weaknesses

The quality assurance materials contain no cultural competency measurement component despite an emphasis on cultural adaptations of the program. Further, there is minimal explanation as to how supervisors should interpret the changes in participants' scores from pre- to posttest and how they should analyze this information.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Manual	$40 each	Yes
Background reading information	Free	No
Implementation materials	Free	No
Students and Trauma DVD	$15 each	No
2-day, on- or off-site training (includes pretraining consultation)	$4,000 for 12-15 participants, plus travel expenses	No

Clinical consultation	$200 per hour	No
Fidelity checklists with instructions	Free	No
Review of tape recordings for fidelity monitoring	$100 per hour	No

Additional Information

The cost of implementation can be calculated based on the salary of a full-time, school-based mental health professional who is devoted to delivering CBITS. One professional can screen students in the general school population and select students with elevated symptoms, delivering up to 30 CBITS groups per academic year (6-8 students per group), for a total of about 210 students. Assuming an approximate staffing cost of $90,000 per year for a full-time social worker, the estimated cost per participant is $430.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Cohen, J. A., Jaycox, L. H., Mannarino, A. P., Walker, D. W., Langley, A. K., & DuClos, J. L. (2009). Treating traumatized children after Hurricane Katrina: Project Fleur-de-Lis. Clinical Child and Family Psychology Review, 12(1), 55-64.

Dean, K., Langley, A., Kataoka, S., Jaycox, L. H., Wong, M., & Stein, B. D. (2008). School-based disaster mental health services: Clinical, policy, and community challenges. Professional Psychology: Research and Practice, 39(1), 51-57.

Feldman, E. (2007). Implementation of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) with Spanish-speaking, immigrant middle-school students: Is effective, culturally competent treatment possible within a public school setting? (Doctoral dissertation, University of Wisconsin-Madison, 2007). Dissertation Abstracts International, 68(A), 1325.

Jaycox, L. H., Langley, A. K., Stein, B. D., Wong, M., Sharma, P., Scott, M., et al. (2009). Support for students exposed to trauma: A pilot study. School Mental Health, 1(2), 49-60.

Kataoka, S. H., Fuentes, S., O'Donoghue, V. P., Castillo-Campos, P., Bonilla, A., Halsey, K., et al. (2006). A community participatory research partnership: The development of a faith-based intervention for children exposed to violence. Ethnicity & Disease, 16(1 Suppl. 1), S89-S97.

Kataoka, S., Nadeem, E., Langley, A. K., Jaycox, L., Stein, B. D., & Wong, M. (in press). Implementing school mental health program.. post-Katrina Louisiana: A focus group study. American Journal of Preventive Medicine.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. Journal of Behavior Therapy and Experimental Psychiatry, 40(1), 169-178.

Contact Information

To learn more about implementation, contact:
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alangley@mednet.ucla.edu

To learn more about research, contact:
Lisa H. Jaycox, Ph.D.
(703) 413-1100 ext 5118
jaycox@rand.org

Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.cbitsprogram.org**

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS has been tested primarily with children in grades 3 through 8, as in the three studies reviewed in this summary. It also has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma and/or were exposed to a catastrophic weather event such as Hurricane Katrina.

CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel.

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	**Review Date: March 2010** 1: PTSD symptoms 2: Depression symptoms 3: Psychosocial dysfunction
Outcome Categories	Mental health Social functioning
Ages	6-12 (Childhood)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	School
Geographic Locations	Urban
Implementation History	Since it was first used in the 2000-2001 school year, CBITS has been implemented widely across the United States and is being actively disseminated through the National Child Traumatic Stress Network. Implementation sites have been located in California, the District of Columbia, Illinois, Louisiana, Maryland, Mississippi, Montana, Tennessee, and Wisconsin, among other States. Internationally, CBITS is being implemented in Australia, China, Guyana, and Japan.
[illegible] Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	CBITS has been adapted for use with traumatized Latino immigrant children, and worksheets and parent handouts have been translated into Spanish. The program also has been adapted for use in American Indian reservation schools to reflect the traditional culture and wellness practices of the participating tribes. In

	addition, program worksheets have been adapted for use among low-literacy populations and youth in foster care.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research

Review Date: March 2010

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

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Study 2

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Study 3

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Supplementary Materials

Foa, E., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. Journal of Clinical Child Psychology, 30(3), 376-384.

Jaycox, L. H., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudera, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child and Adolescent Psychiatry, 41(9), 1104-1110.

Morsette, A., Schuldberg, D., van den Pol, R., Swaney, G., & Stolle, D. (2009). Culturally informed cognitive behavioral interventions for trauma symptoms: Group therapy in rural American Indian reservation schools. Manuscript submitted for publication.

Outcomes

Outcome 1: PTSD symptoms

Description of Measures	The Child PTSD Symptom Scale (CPSS), the children's version of the Posttraumatic Diagnostic Scale for Adults, was used to assess PTSD symptoms. The CPSS is a 17-item self-report measure that asks children to rate how often in the past month they were bothered by symptoms on a scale from 0 (not at all) to 3 (almost always), yielding a total score ranging from 0 to 51, with higher scores indicating more PTSD symptoms.
Key Findings	In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean CPSS score at 3-month follow-up than the wait-list group (8.9 vs. 15.5; p < .001). The effect size for this finding was large (Cohen's d = 1.08). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CPSS scores was no longer significant (8.2 vs. 7.2). In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CPSS score decreased significantly from 19 to 13

	($p < .001$), while the wait-list group had a nonsignificant decrease from 18 to 16. In addition, in a subsample analysis of students with clinically significant PTSD symptoms at baseline (CPSS score > 11), the improvement in mean CPSS score was significantly greater for the intervention group (from 20 to 13) than for the wait-list group (from 19 to 16; $p < .05$). In a third study, students in grades 4-8 who reported significant levels of mental health symptoms including PTSD were randomly assigned to receive CBITS or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Mean CPSS scores improved significantly from baseline to 10-month follow-up in both groups, decreasing from 22.82 to 12.00 for the TF-CBT group ($p < .01$) and from 21.98 to 15.81 for the CBITS group ($p < .001$). While both treatments led to a significant reduction of PTSD symptoms, the difference between groups was not statistically significant.
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.1 (0.0-4.0 scale)

Outcome 2: Depression symptoms

Description of Measures	Symptoms of depression were assessed using the Children's Depression Inventory (CDI). The CDI is a 27-item self-report instrument that assesses cognitive, affective, and behavioral symptoms of depression in children. Twenty-six of the 27 items were used; 1 item assessing suicidality was removed at the request of school personnel. For each item, the child was asked to describe his or her feelings during the past 2 weeks, with three possible response options associated with scores of 0 (an absence of symptoms), 1 (mild symptoms), and 2 (definite symptoms). Scores range from 0 to 52 points, with higher scores indicating more depressive symptoms.
Key Findings	In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a lower mean CDI score at 3-month follow-up than the wait-list group (9.4 vs. 12.7; $p = .014$). The effect size for this finding was small (Cohen's $d = 0.45$). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CDI scores was no longer significant (9.0 vs. 10.0). In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CDI score decreased significantly from 16 to 14 ($p < .001$), while the wait list group's mean CDI score remained unchanged at 16. In addition, in a subsample analysis of students with clinically significant depression symptoms at baseline (CDI score = 18), the improvement in mean CDI score at 3-month follow-up was significantly greater for the intervention group (from 23 to 18) than for the wait-list group (from 24 to 23; $p < .05$). In a third study, students in grades 4-8 who reported significant levels of mental health symptoms including PTSD were randomly assigned to receive CBITS or TF-CBT. Mean CDI scores improved significantly for both groups from baseline to 10-month follow-up, decreasing from 15.43 to 11.14 for the TF-CBT group ($p = 0.17$) and from 13.40 to 9.72 for the CBITS group ($p < .001$).
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 3: Psychosocial dysfunction

scription of Measures	Psychosocial dysfunction was assessed using the 35-item Pediatric Symptom Checklist (PSC). This instrument asks the child's parent to rate the frequency of the child's emotional and behavioral problems on a scale from 0 (never) to 2 (often), yielding a total score of 0 to 70 points, with higher scores indicating greater dysfunction.
Key Findings	Sixth-grade students who reported exposure to violence and had clinically significant PTSD

	symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean PSC score at 3-month follow-up compared with the wait-list group (12.5 vs. 16.5; p = .007). The effect size associated with this finding was medium (Cohen's d = 0.77). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean PSC scores was no longer significant (9.4 vs. 8.9).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood)	56% Female 44% Male	100% Race/ethnicity unspecified
Study 2	6-12 (Childhood)	50% Female 50% Male	100% Hispanic or Latino
Study 3	6-12 (Childhood)	56% Female 44% Male	48% White 46% Black or African American 5% Hispanic or Latino 1% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: PTSD symptoms	4.0	4.0	2.0	3.0	2.0	3.5	**3.1**
2: Depression symptoms	4.0	3.5	2.0	3.0	2.0	3.5	**3.0**
3: Psychosocial dysfunction	3.5	4.0	3.0	3.5	2.5	4.0	**3.4**

Study Strengths

Relevant and psychometrically sound measurement instruments were used in the studies. The measures have high levels of reliability and validity and have been widely used in other studies. Missing data were handled well and were factored into analyses (e.g., analyses used multiple imputation; intent-to-treat was used in two of the studies). A variety of analyses were used across the three studies, and the analyses generally were appropriate for the type of data collected.

Study Weaknesses

Despite the availability of a treatment manual and clinician training, the methods used to assess intervention fidelity varied across the three studies and overall were not systematically strong. Several important confounding variables were not resolved in the studies, including baseline differences between completers and noncompleters, lack of blinding to treatment condition, a mixed approach to

making condition assignments, and differential attrition across treatment groups.

Readiness for Dissemination

Review Date: March 2010

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Cognitive Behavioral Intervention for Trauma in Schools Dissemination Toolkit

Jaycox, L. (2004). Cognitive Behavioral Intervention for Trauma in Schools. Longmont, CO: Sopris West Educational Services.

Program Web site, http://www.tsaforschools.org/index.php?option=com_content&task=view&id=81&Itemid=69

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	3.5	**3.8**

Dissemination Strengths

Implementation materials are thorough and well developed. The manual and toolkit are easy to read, well organized, and clearly formatted. Detail is provided on screening students for appropriateness for inclusion in the program. Training packages are comprehensive and varied. The developers are clear about the skills and competences required by clinicians and supervisors who implement the program. Ongoing support is provided via remote telephone consultation and an online peer support network and resource library. Several options for fidelity monitoring are described, including the scoring of live or audiotaped sessions, therapist self-ratings, and supervision, and forms and rating instructions are included. Fidelity monitoring is stressed as an important component of the program.

Dissemination Weaknesses

The quality assurance materials contain no cultural competency measurement component despite an emphasis on cultural adaptations of the program. Further, there is minimal explanation as to how supervisors should interpret the changes in participants' scores from pre- to posttest and how they should analyze this information.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Manual	$40 each	Yes
Background reading information	Free	No
Implementation materials	Free	No
Students and Trauma DVD	$15 each	No
2-day, on- or off-site training (includes pretraining consultation)	$4,000 for 12-15 participants, plus travel expenses	No

Clinical consultation	$200 per hour	No
Fidelity checklists with instructions	Free	No
Review of tape recordings for fidelity monitoring	$100 per hour	No

Additional Information

The cost of implementation can be calculated based on the salary of a full-time, school-based mental health professional who is devoted to delivering CBITS. One professional can screen students in the general school population and select students with elevated symptoms, delivering up to 30 CBITS groups per academic year (6-8 students per group), for a total of about 210 students. Assuming an approximate staffing cost of $90,000 per year for a full-time social worker, the estimated cost per participant is $430.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Cohen, J. A., Jaycox, L. H., Mannarino, A. P., Walker, D. W., Langley, A. K., & DuClos, J. L. (2009). Treating traumatized children after Hurricane Katrina: Project Fleur-de-Lis. Clinical Child and Family Psychology Review, 12(1), 55-64.

Dean, K., Langley, A., Kataoka, S., Jaycox, L. H., Wong, M., & Stein, B. D. (2008). School-based disaster mental health services: Clinical, policy, and community challenges. Professional Psychology: Research and Practice, 39(1), 51-57.

Feldman, E. (2007). Implementation of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) with Spanish-speaking, immigrant middle-school students: Is effective, culturally competent treatment possible within a public school setting? (Doctoral dissertation, University of Wisconsin-Madison, 2007). Dissertation Abstracts International, 68(A), 1325.

Jaycox, L. H., Langley, A. K., Stein, B. D., Wong, M., Sharma, P., Scott, M., et al. (2009). Support for students exposed to trauma: A pilot study. School Mental Health, 1(2), 49-60.

Kataoka, S. H., Fuentes, S., O'Donoghue, V. P., Castillo-Campos, P., Bonilla, A., Halsey, K., et al. (2006). A community participatory research partnership: The development of a faith-based intervention for children exposed to violence. Ethnicity & Disease, 16(1 Suppl. 1), S89-S97.

Kataoka, S., Nadeem, E., Langley, A. K., Jaycox, L., Stein, B. D., & Wong, M. (in press). Implementing school mental health programs post-Katrina Louisiana: A focus group study. American Journal of Preventive Medicine.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. Journal of Behavior Therapy and Experimental Psychiatry, 40(1), 169-178.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.cbitsprogram.org**

Fourth R: Skills for Youth Relationships

The Fourth R: Skills for Youth Relationships is a curriculum for 8th- and 9th-grade students that is designed to promote healthy and safe behaviors related to dating, bullying, sexuality, and substance use. Based on social learning theory and grounded in stages of social development, the Fourth R focuses on improving students' relationships with peers and dating partners and avoiding symptomatic problem behaviors (e.g., violence, aggression).

The Fourth R is composed of three units: (1) personal safety and injury prevention, (2) healthy growth and sexuality, and (3) substance use and abuse. Each unit contains seven 75-minute classes, which are delivered by trained teachers and integrated into the school's standard health and physical education curriculum. The Fourth R engages students with exercises to define and practice the rights and responsibilities associated with healthy relationships. The curriculum includes many examples of the types of conflicts faced by teens on a daily basis, and examples of both peer and dating conflicts are used concurrently (where possible) so that youth who are not dating will find the material relevant. The Fourth R makes extensive use of role-playing, with feedback from peers and teachers, to increase students' interpersonal skills and problem-solving abilities. Boys and girls participate in slightly different exercises and activities, which are intended to raise their level of awareness of social norms and minimize gender-based defensive or hostile reactions.

Descriptive Information

Areas of Interest	Mental health promotion Substance abuse prevention
.comes	**Review Date: February 2011** 1: Physical dating violence 2: Condom use 3: Violent delinquency
Outcome Categories	Violence
Ages	13-17 (Adolescent)
Genders	Male Female
Races/Ethnicities	Non-U.S. population
Settings	School
Geographic Locations	Suburban Rural and/or frontier
Implementation History	Implementation of the Fourth R began in 2004, and the program is used in more than 1,200 schools (1,000 in Canada and 200 in the United States), reaching more than 100,000 students each year. In Canada, the Fourth R has been implemented in Alberta, British Columbia, Manitoba, Newfoundland, Northwest Territories, Nova Scotia, Nunavut, Ontario, Saskatchewan, and Yukon. In the United States, the program has been implemented in Alabama, Alaska, California, Colorado, Florida, Idaho, Illinois, Kansas, Massachusetts, Michigan, Missouri, New York, North Dakota, Ohio, Oklahoma, Rhode Island, Texas, and Washington. Four U.S. sites are using the program as part of the Robert Wood Johnson Foundation's Start Strong teen dating violence prevention initiative: Boise, Idaho; Bronx, New York; Providence, Rhode Island; and Wichita, Kansas. The Fourth R also has been implemented in Australia, Portugal, and Spain. Two evaluations of the Fourth R have been conducted in Canada, and a third evaluation is being conducted in the United States.

NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: No
Adaptations	The Fourth R has been adapted for use with Canadian Aboriginal populations (e.g., First Nations, Métis, Inuit), Catholic school students, and students in alternative education settings. Program materials have been translated into French, Portuguese, and Spanish.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Universal

Quality of Research

Review Date: February 2011

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Crooks, C. V., Scott, K., Ellis, W., & Wolfe, D. A. (2011). Impact of a universal school-based violence prevention program on violent delinquency: Distinctive benefits for youth with maltreatment histories. Child Abuse and Neglect, 35(6), 393-400. (NOTE: At the time of the NREPP review, the manuscript of this article had been submitted for publication but not yet accepted.)

Crooks, C. V., Scott, K. L., Wolfe, D. A., Chiodo, D., & Killip, S. (2007). Understanding the link between childhood maltreatment and violent delinquency: What do schools have to add? Child Maltreatment, 12(3), 269-280.

Wolfe, D. A., Crooks, C., Jaffe, P., Chiodo, D., Hughes, R., Ellis, W., et al. (2009). A school-based program to prevent adolescent dating violence: A cluster randomized trial. Archives of Pediatrics and Adolescent Medicine, 163(8), 692-699.

Supplementary Materials

Wolfe, D. A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A.-L. (2001). Development and validation of the Conflict in Adolescent Dating Relationships Inventory. Psychological Assessment, 13(2), 277-293.

Outcomes

Outcome 1: Physical dating violence

Description of Measures	Physical dating violence (PDV) was assessed using 8 items from the Conflict in Adolescent Dating Relationships Inventory (CADRI), a self-report measure. Students responded to each item with "yes" or "no" to indicate behaviors they had used in the past year toward a boyfriend/girlfriend while they were having an argument, angry at one another, or having a fight. PDV was indicated if the student responded with "yes" to one or more of the items that involved physical abuse or threats to harm (e.g., "I pushed, shoved, or shook him/her," "I threatened to hurt him/her").
Key Findings	Participating public schools in Ontario, Canada, were randomly assigned to an intervention group, which received the Fourth R, or to a control group, which received the school's standard grade 9 health and physical education curriculum. Findings at the 2.5-year follow-up included the following: • A smaller percentage of students in the intervention group reported engaging in PDV in the past year compared with students in the control group (7.4% vs. 9.8%; p = .05). • A smaller percentage of male students in the intervention group reported engaging in PDV in the past year compared with male students in the control group (2.7% vs. 7.1%; p = .002). • Similar percentages of female students in both groups reported engaging in PDV in the past year (11.9% for the intervention group and 12.0% for the control group).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 2: Condom use	
Description of Measures	Condom use was assessed using a question from the University of Victoria's Healthy Youth Survey. Only sexually active students responded to this question, and condom use was defined as the male always wearing a condom.
Key Findings	Participating public schools in Ontario, Canada, were randomly assigned to an intervention group, which received Fourth R, or to a control group, which received the school's standard grade 9 health and physical education curriculum. Findings at the 2.5-year follow-up included the following: • A larger percentage of sexually active male students in the intervention group reported condom use compared with sexually active male students in the control group (68% vs. 59%; $p < .01$). • However, a smaller percentage of sexually active female students in the intervention group reported partner condom use compared with sexually active female students in the control group (44% vs. 51%; $p < .01$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Outcome 3: Violent delinquency	
Description of Measures	Violent delinquency was assessed using 8 items from the Canadian National Longitudinal Survey of Children and Youth. Students indicated whether they engaged in any of the following behaviors over the past 3 months: (1) "fought with someone to the point where they needed care for their injuries," (2) "been in a fight where you hit someone with something other than your hands," (3) "carried a knife for the purpose of defending yourself or using it in a fight," (4) "carried a gun other than for hunting or target shooting," (5) "carried any other weapon such as a stick or club," (6) "threatened someone in order to get their money or things," (7) "tried to force someone to have sex with you," and (8) "set fire on purpose to a building, car, or something else not belonging to you." Students who indicated that they engaged in at least two of these behaviors were classified as exhibiting violent delinquency. Data were then statistically analyzed to determine the risk of violent delinquency.
Key Findings	Participating public schools in Ontario, Canada, were randomly assigned to an intervention group, which received Fourth R, or to a control group, which received the school's standard grade 9 health and physical education curriculum. Findings at the 2.5-year follow-up indicated that among students with a history of childhood maltreatment, those in the intervention group had a 3% risk of violent delinquency and those in the control group had a 46% risk of violent delinquency (odds ratio = 0.66; $p < .05$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
dy 1	13-17 (Adolescent)	53% Female 47% Male	100% Non-U.S. population

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Physical dating violence	3.0	3.0	2.5	2.8	3.0	4.0	**3.0**
2: Condom use	2.0	2.0	2.5	2.0	3.0	4.0	**2.6**
3: Violent delinquency	2.0	3.0	2.5	2.5	3.0	4.0	**2.8**

Study Strengths

Research established the psychometric properties of the CADRI items, which had good test-retest reliability and convergent/divergent validity. Teachers participated in a training workshop and received detailed lesson plans, training videos, role-play demonstrations, and individual feedback from an experienced educator. Self-report fidelity checklists completed by teachers indicated that 89% of the intervention lessons were completed. Participating schools were stratified by size and location before randomization. Intent-to-treat analyses were conducted with all participant data. Separate analyses were conducted with a subsample of students who had been dating in the year before the follow-up.

Study Weaknesses

Classroom sessions were not observed by an independent rater for fidelity. Student data were collected by self-report only. Analysis indicated that students lost to attrition (12% of the sample) were more likely to be male and more likely to report problem alcohol use introducing potential confounds.

Readiness for Dissemination

Review Date: February 2011

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Gibbings, P., Crooks, C., & Hughes, R. (2009). Youth Safe Schools Committee manual: A guide for the creation and operation of a committee of students who support and encourage healthy-living choices among teens. London, Canada: Centre for Addiction and Mental Health, Centre for Prevention Science.

Program Web site, http://www.youthrelationships.org

The Teen Files Series [4 DVDs]:

- Binge drinking blowout. (1999).
- Smoking: Truth or dare? (2000).
- The truth about drugs. (1999).
- The truth about sex. (2000).

Wolfe, D., Crooks, C., Hughes, R., & Jaffe, P. (2009). Youth Relationships Program: Featuring the Fourth R for Healthy Relationships: A relationship-based program for 8th grade physical and health education. London, Canada: Centre for Addiction and Mental Health, Centre for Prevention Science.

Wolfe, D., Crooks, C., Hughes, R., Jaffe, P., & Chiodo, D. (2010). Master trainer manual. 4R: Strategies for healthy youth relationshi London, Canada: Centre for Addiction and Mental Health, Centre for Prevention Science. Includes:

- Master Trainer Manual [CD-ROM]
- Media Violence: Understanding Media Literacy, a Guide for Parents [Pamphlet]
- Strategies for Healthy Youth Relationships [Pamphlet]
- Wolfe, D. A. (2007). What parents need to know about teens: Facts, myths and strategies. Toronto, Canada: Centre for Addiction and Mental Health.

Other implementation materials:

- Name the Violence (Headings/Scenarios) [Laminated cards]
- Quiz (Fact or Myth?) [Trade cards]
- Role-Play Examples [DVD]

Skills for Effective Relationships [2 DVDs]
Youth Relationships Program Handouts, Overheads, Parent Newsletters, and Unit Test [CD-ROM]

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	4.0	**4.0**

Dissemination Strengths

Comprehensive grade-specific implementation materials include DVDs, CD-ROMs, and a detailed manual. Each lesson is sequenced and includes objectives, learning strategies, and overheads. Role-playing is used for practicing skills. The Master Trainer Manual includes a training agenda, copies of training slides with detailed notes, model role-play scripts, and background information. On-site trainings for teachers and master trainers are offered; trainings include an opportunity for participants to provide feedback to each other during role-play scenarios and to the trainer via a feedback form. A fidelity checklist for each component, a student satisfaction survey, and a teacher implementation questionnaire are available to support quality assurance.

mination Weaknesses

No weaknesses were identified by reviewers.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Fourth R Curriculum Binder, for teachers (includes cards; a DVD with role-play examples; two DVDs with skills for effective relationships; and a CD-ROM with handouts, overheads, a unit test, and other resources for printing)	$135 per binder	Yes
4-DVD Teen File Series: • Binge Drinking Blowout • Smoking: Truth or Dare? • The Truth About Drugs • The Truth About Sex	$325 per set	No
Youth Safe Schools Committee Manual	$25 each	No
day, off-site teacher training workshop	$150 per person	No
1-day, on-site teacher training workshop	$1,500 for 25 participants plus trainer travel expenses	No
1.5-day, on-site master trainer training	$12,500 for 25 participants plus trainer	No

	travel expenses	
Master Trainer Manual (includes fidelity checklists)	$150 each	No
2-day, on-site consultation	$2,000 plus travel expenses	No
Phone and email support	Free	No
Student Satisfaction Questionnaire	Free	No
Teacher Implementation Questionnaire	Free	No

Additional Information

In the study reviewed by NREPP, approximately 1,700 students participated in the program, at an average cost of $16 per student. This amount included expenses for teacher release time for training and the cost of curriculum materials.

Replications

No replications were identified by the developer.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- http://www.youthrelationships.org